For Office Use Only

Reset Form

State Corporation Commission
Bureau of Insurance
Life and Health Division
Post Office Box 1157
Richmond, VA 23218

For Office Use Only

I wish to file a complaint: (please print)

1. My name is: Day Telephone:
(Area Code-Number)
2. Mailing Address:
(Street/Apt. Number)
City: State: ZIP:
3. If you are not the insured or the person on whose behalf this complaint is being filed, please tell us who is and explain your relationship:
4. I am complaining against:
(Name of Insurance Company, Agent or Health Maintenance Organization (HMO))
(Address, if known)
5. The Insured's Policy, Certificate or ID Number is:
6. The type of insurance is: ☐ Life ☐ Health ☐ Annuity ☐ Credit
My Insurance Plan is: ☐ Group ☐ Individual ☐ HMO*

***Note:** HMOs are required by law to have internal grievance procedures for their members, and the procedure to follow is explained in your contract or evidence of coverage. Before filing a complaint against an HMO, you are urged to take advantage of your HMO's grievance procedure. If your HMO complaint involves quality of care issues, the Bureau of Insurance will forward your complaint to the Virginia Department of Health for a response.*

The details of my complaint are: (type or print clearly, use other side if needed)

Please use separate sheet to provide details.

I am enclosing copies of all correspondence or other papers relating to this matter that may assist the Bureau of Insurance, or the Department of Health, in its evaluation of my complaint. I understand and agree that a copy of this form and any or all of the enclosed information may be provided to the party complained against. I also agree that by signing this form I authorize the Bureau of Insurance, or the Department of Health, to obtain any information required to evaluate my complaint.

(Date) (Signature)